Senate

General Assembly

File No. 292

February Session, 2018

Substitute Senate Bill No. 380

Senate, April 5, 2018

The Committee on Insurance and Real Estate reported through SEN. LARSON of the 3rd Dist. and SEN. KELLY of the 21st Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING ADVERSE DETERMINATION REVIEWS AND EXTERNAL REVIEW PROCESSES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(b) With respect to a nonurgent care request:

(1) (A) For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but not later than fifteen calendar days after the date the health carrier receives such request, and shall notify the covered person and, if applicable, the covered person's authorized representative of such determination, whether or not the carrier certifies the provision of the benefit.

(B) If the review under subparagraph (A) of this subdivision is a review of a grievance involving a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

(C) (i) Notwithstanding subparagraph (B) of this subdivision, if a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy to dispense a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include confirmation of the availability of payment for such supply of such drug.

(ii) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(iii) The provisions of this subparagraph shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

(2) For a retrospective review request, a health carrier shall make a determination within a reasonable period of time, but not later than thirty calendar days after the date the health carrier receives such request.

(3) The time periods specified in subdivisions (1) and (2) of this subsection may be extended once by the health carrier for up to fifteen calendar days, provided the health carrier:

(A) Determines that an extension is necessary due to circumstances beyond the health carrier's control; and

(B) Notifies the covered person and, if applicable, the covered person's authorized representative prior to the expiration of the initial time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(4) (A) If the extension pursuant to subdivision (3) of this subsection is necessary due to the failure of the covered person or the covered person's authorized representative to provide information necessary to make a determination on the request, the health carrier shall:

(i) Specifically describe in the notice of extension the required information necessary to complete the request; and

(ii) Provide the covered person and, if applicable, the covered person's authorized representative with not less than forty-five calendar days after the date of receipt of the notice to provide the specified information.

(B) If the covered person or the covered person's authorized representative fails to submit the specified information before the end of the period of the extension, the health carrier may deny certification of the benefit requested.

Sec. 2. Subsection (c) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of the clinical peer or peers involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) The clinical peer or peers conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized representative, as applicable, any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to

the covered person until the covered person has been notified of the review decision.

(4) (A) Notwithstanding subdivision (3) of this subsection, if a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy to dispense a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include confirmation of the availability of payment for such supply of such drug.

(B) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(C) The provisions of this subdivision shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

Sec. 3. Subsection (b) of section 38a-591f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(b) (1) A covered person or the covered person's authorized representative may file a grievance of an adverse determination that was not based on medical necessity with the health carrier not later than one hundred eighty calendar days after the covered person or the

covered person's representative, as applicable, receives the notice of an adverse determination.

(2) (A) If a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy to prescribe a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include confirmation of the availability of payment for such supply of such drug.

(B) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(C) The provisions of this subdivision shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

[(2)**]** (3) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative not later than three business days after the health carrier receives a grievance that the covered person or the covered person's authorized representative, as applicable, is entitled to submit written material to the health carrier to be considered when conducting a review of the grievance.

[(3)**]** (4) (A) Upon receipt of a grievance, a health carrier shall designate an individual or individuals to conduct a review of the grievance.

(B) The health carrier shall not designate the same individual or individuals who denied the claim or handled the matter that is the subject of the grievance to conduct the review of the grievance.

(C) The health carrier shall provide the covered person and, if applicable, the covered person's authorized representative with the name, address and telephone number of the individual or the organizational unit designated to coordinate the review on behalf of the health carrier.

Sec. 4. Subsection (b) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(b) (1) Except as otherwise provided under subdivision (2) of this subsection or subsection (d) of this section, a covered person or a covered person's authorized representative shall not file a request for an external review or an expedited external review until the covered person or the covered person's authorized representative has exhausted the health carrier's internal grievance process.

(2) A health carrier may waive its internal grievance process and the requirement for a covered person to exhaust such process prior to filing a request for an external review or an expedited external review.

(3) (A) If a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy to dispense a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include

confirmation of the availability of payment for such supply of such drug.

(B) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(C) The provisions of this subdivision shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	38a-591d(b)
Sec. 2	*January 1, 2019*	38a-591e(c)
Sec. 3	*January 1, 2019*	38a-591f(b)
Sec. 4	*January 1, 2019*	38a-591g(b)

Statement of Legislative Commissioners:
In Sections 1(b)(1)(C)(ii) and 1(b)(1)(C)(iii), 2(c)(4)(B), 3(b)(2) and 4(b)(3) "licensed" was inserted before "participating provider" for consistency.

INS *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 19 $	FY 20 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Plan)	GF&TF - Cost	At least $1 million	At least $2.1 million

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 19 $	FY 20 $
Various Municipalities	STATE MANDATE - Cost	See Below	See Below

Explanation

The bill will result in a cost of approximately $1 million in FY 19 and $2.1 million in FY 20 to comply with the prescription coverage provisions of the bill during an adverse determination review. Pursuant to the SEBAC 2017 Agreement, the state implemented a standard formulary for the state employee and retiree health plan and implemented prior authorization/utilization review procedures effective October 1, 2017.

The bill will increase costs to fully-insured municipal plans whose health insurers do not currently follow the coverage requirements of the bill while the utilization review is being conducted. The cost to municipalities will be reflected in premiums for policies effective on or after January 1, 2019. Due to federal law, self-insured municipalities are not governed by the provisions of CGS §38a-591d.

The Out Years

The fiscal impact identified above will continue into the future and subject to the prescriptions required to be covered. The impact to fully-insured municipalities will be reflected in future premiums.

OLR Bill Analysis

SB 380

AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING ADVERSE DETERMINATION REVIEWS AND EXTERNAL REVIEW PROCESSES.

SUMMARY

This bill requires health carriers (e.g., insurers and HMOs) to authorize a covered person's pharmacy to dispense a temporary supply of a prescribed drug when the covered person, or his or her authorized representative, files a grievance or requests an adverse determination review related to the drug (see BACKGROUND). The bill applies to initial utilization reviews, internal grievance reviews, and external reviews. These reviews are one factor used to determine if a specific medical service is reimbursable by the individual's health plan.

The requirement does not apply to (1) a prescription for a schedule II or III drug (see BACKGROUND) or (2) a review of an adverse determination concerning the substitution of a generic or other brand name drug, unless the prescriber has specified no substitutions.

EFFECTIVE DATE: January 1, 2019

PHARMACY AUTHORIZATION

Under the bill, health carriers must electronically authorize the covered person's pharmacy to dispense a temporary supply of the drug and confirm that payment is available. The temporary supply must be sufficient for the review's duration.

By law, health carriers generally must complete reviews of adverse determinations within 30 days after receiving the grievance. However, expedited reviews must be completed within 72 hours, or within 24

hours for expedited reviews of treatment for certain substance abuse or mental disorders. (At the covered person's request, urgent care reviews may be expedited).

PRESCRIBER CONCURRENCE

Within 24 hours after notifying the pharmacy but before the pharmacy dispenses the drug, the bill requires carriers to contact the licensed prescriber to confirm that he or she concurs with dispensing a temporary drug supply. If the prescriber does not concur, the health carrier must cancel the authorization.

BACKGROUND

Adverse Determination

An adverse determination is a denial of coverage for a specific benefit. Generally, benefit reviews have up to three steps: (1) an initial review, to determine if the procedure is covered; (2) a grievance review (i.e., internal review), which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and (3) an external review, which is conducted when a covered person exhausts a health carrier's internal process and appeals the carrier's adverse determination to the Connecticut Insurance Department (CID). External reviews, also called final adverse determination reviews, are conducted by an independent review organization assigned by CID.

Drug Schedules

Federal law categorizes drugs into one of five schedules based on the (1) potential and risks of abuse and (2) safety, importance, and range of accepted medical treatments. The schedules range from I (high potential for abuse and little to no medical value) to V (low potential for abuse and accepted medical uses). For example, opioid painkillers (e.g. Vicodin) are generally categorized as Schedule II or III, depending on their potential risks.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 19 Nay 2 (03/20/2018)